Testimony in Support of SB 800
March 11, 2015

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Senator Gerratana, Representative Ritter, distinguished members of the Public Health Committee.

My name is Bruce Baxter. I am the CEO of New Britain Emergency Medical Services, Inc., the Immediate Past President of the CT EMS Chiefs Association and a paramedic. I am here today to testify in support of SB 800, ***An Act Concerning a Municipal Pilot Program Allowing Emergency Medical Services Personnel to Provide Community Based Paramedicine.***

My testimony reflects the opinion of New Britain Emergency Medical Services as well as that of the CT EMS Chiefs Association.

As we all know healthcare in undergoing unprecedented reform with a focus on achieving sustained enhancements in the quality of care provided, patient experience and satisfaction and economies of scale. The complexities of our healthcare system are such that the change is required to implement and achieve these objectives are challenging from a patient, operational and fiscal perspective is daunting. The cultural change associated with the reformation of healthcare takes time. Declining revenues and increasing demand present a real threat of system collapse in certain segments of the healthcare market.

9-1-1 Emergency Medical Service providers serve their respective community's as the public health safety net by responding to the episodic needs of the populace at any time of day, regardless of the patients' ability to pay for the services provided to render life saving care. They are the stop gap often times when the current healthcare system fails to meet the patients' needs; the surrogate primary care provider and healthcare system advocate and navigator. As a system EMS has demonstrated its ability as a highly reliable organization to get the right people to the right place at the right time consistently.

Adding mobile integrated health care-community paramedicine into the existing EMS infrastructure is a logical opportunity for the healthcare community to gain additional enhancement and cost savings.

In 2004, collaboration between an academic medical center, an insurance company and 37 municipal EMS providers organizations created the first sustained successful mobile integrated health care/community paramedic project in the United States with the goal of leveraging the unique opportunities community based EMS providers organizations provide to improve the

health of the participating population. The initial focus on injury prevention, wellness, vaccination compliance, rapidly gave way to other opportunities inclusive of:

- Reduction of 9-1-1 demand though focused patient education, home visits and improved healthcare system navigation.
- Reduction of hospital re-admissions Emergency Department visits for select clinical conditions.
- Sudden un-enrollment of hospice patients during the last 72 hours of life.

While much of the data is proprietary to the sponsoring insurance company, the results clearly demonstrated that EMS providers could successfully influence the three key components of the triple aim through an integrated and collaborative initiative.

The initial work in Western Pennsylvania has been successfully reproduced in Wake County North Carolina, Dallas- Fort Worth Texas, Reno Nevada, and Prosser County Hospital District, Washington leading to 350 established MIHC Programs and an additional 1000 reportedly in the start up phase. Data from these sites clearly demonstrate significant cost savings, improved patient experience and enhanced levels of care

Each program possesses shared qualities:

- They do not compete with any existing healthcare provider or organization. They compliment and facilitate their services by providing services on an episodic basis as requested.
- They are designed to meet and fill the unique healthcare gaps that exist in a specific community or service area. The programs focus on four areas:
    - Reduction of ED visits/9-1-1 demand through education, MIHC home visits and enhanced navigation.
    - Reduction of hospital re-admissions for select diagnostic groups of patients through episodic home visitation services.
    - Reduction of Hospice Revocation during the end stage.
- The services rendered generally are with in the national scope of practice of the EMS providers.
- They assure integration and close continuous collaboration with the community or area wide healthcare providers and institutions.
- They are data driven.
- They produce real cost savings to the healthcare system.
- The costs of the programs are underwritten initially by start up grants mechanisms, but sustained through a re-allocation of achieved cost savings.

From an urban EMS perspective, our demand for service is increasing while reimbursements are decreasing. The ability for essential 9-1-1 services to keep pace with the demand in today's current economic environment places an additional tax burden on communities who can ill

afford to add expense to their budgets. The implementation of Mobile Integrated Healthcare provides an opportunity for slowing the growth in demand by changing the way in which we produce and deliver services while lowering the overall cost of healthcare, improving the quality of care provided to the patient and enhancing their satisfaction.

As the language in this bill is largely conceptual, I would suggest the Public Health Committee establish a Legislative Sub Committee or Task Force with a defined goal of drafting a detailed bill that includes the requisite elements for any pilot programs including a process for program approval. Enabling legislation must address the following:

- Provide flexibility to assure a program addresses the unique healthcare gaps-challenges in a local community or defined geographical area.
- Define the role and scope of practice of a mobile integrated healthcare provider.
- Assure any approved program does not duplicate or compete with an existing healthcare services provider in a specific geographical area.
- Requisite physician oversight is in place from a emergency, primary care or appropriate specialty/subspecialty physician.
- Is collaborative and fully integrated with the local health care community.
- Has the ability to produce meaningful clinical, operational, quality, financial, and patient satisfaction data to support enhancement and continuation of the program.
- Establishes the minimum education standards for Mobile Integrated Healthcare Providers.

The committee should include at least one representative from the following stakeholder groups:

- The Department of Public Health – Office of Emergency Medical Services
- The Connecticut EMS Advisory Board
- The Association of Connecticut Ambulance Providers
- The Connecticut EMS Chiefs Association
- The Connecticut Fire Chiefs Association- EMS Committee
- The Connecticut Hospital Association
- The Connecticut Home Healthcare Association

The addition of Mobile Integrated Healthcare services to the State's current EMS system presents an opportunity to lower the cost of healthcare in the State which improving each patients over all health and healthcare experience.

In closing, I would urge your support of this important legislation